Application to Extend

Oklahoma State Section 1115
Demonstration Project No. 11-W-0048/6

SoonerCare

OVERVIEW

In August of 1995, the state of Oklahoma received approval from the Health Care Financing Administration to operate a managed care program under Section 1915(b) of the Social Security Act. This program, known as ***SoonerCare***, was subsumed under a Section 1115 demonstration waiver effective on October 16, 1995. The initial 1115 waiver was extended for a three-year period in 2001 and is scheduled to expire on December 31, 2003.

This document contains Oklahoma's application to extend the ***SoonerCare*** waiver for another three years, from January 1, 2004 to December 31, 2006. It is organized in accordance with the instructions for waiver extension applications provided by the Centers for Medicare and Medicaid Services (CMS).

The ***SoonerCare*** demonstration consists of three distinct managed care programs that together serve over 70 percent of the Oklahoma Medicaid population. ***SoonerCare Plus*** is a fully-capitated MCO model that operates in 16 of Oklahoma's 77 counties, encompassing the urban centers and surrounding counties of Oklahoma City ("Central" service area), Tulsa ("Northeast" service area) and Lawton ("Southwest" service area). ***SoonerCare Choice*** is a primary care case management (PCCM) program operating in the State's 61 rural counties, and consisting of a partially-capitated PCCM model and an American Indian PCCM model.

The ***SoonerCare*** waiver program was developed to address, in a fiscally responsible manner, the growing imbalance between need and availability of services. Specific program objectives center on access, quality, networks, managed care infrastructure and budget predictability.

Oklahoma has substantially achieved these program objectives, as discussed in greater detail below. With CMS approval, Oklahoma intends to build on the successes of ***SoonerCare*** for another three years.

The remainder of this application is organized into the following sections:

- Project Status by Model
- Achievement of Program Objectives (Access, Networks, Funding Mechanisms, Quality, Budget Neutrality and Compliance with Special Terms and Conditions)
- State Notice Requirements
- Waivers Requested

PROJECT STATUS BY MODEL

SoonerCare Plus

The State currently contracts with three MCOs to serve ***SoonerCare Plus*** enrollees, with enrollees in each service area offered a choice of two MCOs. ***SoonerCare Plus*** enrollment has tripled over the life of the demonstration, growing from 64,631 at the end of the first year of operation in June 1996 to 178,640 in August 2003.

The ***SoonerCare Plus*** health plans receive a monthly capitation payment in return for furnishing a comprehensive package of medical and behavioral health benefits and medically necessary transportation. The health plans are responsible for enrolling each member with a primary care physician to establish a medical home, as well as maintaining a provider network capable of rendering all of the services outlined in the prepaid benefit package in accordance with program access standards.

The plans are also responsible for assisting members to obtain medically necessary services, as part of their care coordination function. In addition to staffing and operating Member Service and Medical Management departments, the plans are required to employ "Exceptional Needs Coordinators" to provide targeted assistance to members with medically diverse needs, as well as those categorized as Aged, Blind or Disabled.

A brief recap of the history of ***SoonerCare Plus*** includes the following milestones:

Date	Milestone
August 1995	***SoonerCare Plus*** is launched, serving TANF beneficiaries in part or all of 10 counties
July 1996	Initial ***Plus*** geographic expansion brings total counties served in part or whole to 14
December 1997	SCHIP beneficiaries added to ***Plus***
July 1997	SMI/SED beneficiaries enrolled on a voluntary basis
July 1998	SMI/SED enrollment converted from voluntary to mandatory
July 1999	Phased-in enrollment begins for persons categorized as ABD (phase-in completed in October 1999)
January 2001	Second ***Plus*** geographic expansion brings total counties served to 16

Date	Milestone
January 2003	Implementation of risk adjusted capitation rates for persons categorized as ABD Reduction in benefit package for adults enrolled in ***Plus*** to correspond to benefit package in ***Choice*** program (reduction made in response to State fiscal constraints)
April 2003	Elimination of retroactive eligibility period for TANF beneficiaries enrolled in managed care
September 2003	Partial restoration of ***Plus*** adult benefit package

SoonerCare Choice

The ***SoonerCare Choice*** primary care case management (PCCM) program consists of two models – a partial capitation PCCM system, and for American Indian members, a case management based PCCM program utilizing the American Indian Provider community.

Partial Capitation PCCM Model

The partial capitation PCCM system makes up the larger portion of ***SoonerCare Choice***. Under this model, Oklahoma contracts with physicians, nurse practitioners and physician assistants to serve as Primary Care Provider/Case Managers, or PCP/CMs, for the rural ***SoonerCare*** population. The PCP/CMs are paid an age- and aid category-adjusted monthly capitation to furnish case management and a defined set of primary and preventive care services, EPSDT screens, immunizations and limited laboratory and radiology services. All other care is reimbursed on a fee-for-service basis.

The number of providers in the partial capitation ***SoonerCare Choice*** system has grown by 35 percent since the program's inception, from 448 in October 1996 to 607 in August 2003. This has enabled program capacity to keep pace with the rise in ***Choice*** enrollment, from 51,247 in June of 1997 to over 153,454 in August 2003; currently one PCP/CM is available per every 252 enrollees.

American Indian PCCM Model

In July 2001, the State released a special fee-for-service PCCM contract for American Indian providers as a means to permit their broader participation in the ***SoonerCare Choice*** program. As of August 2003, the State had signed contracts with 178 American Indian providers/clinics representing all of Oklahoma's tribal entities in the ***Choice*** counties (this is in addition to the 607 providers cited above). Through these contracts,

the State has been able to foster links between American Indian members and Indian Health Service, tribal and urban health clinics for case management services.

Although all medical claims are paid fee-for-service, the providers do receive a prospective per member per month (PMPM) case management fee for American Indian beneficiaries who enroll with them. Enrollment in August 2003 stood at 3,111.

A brief recap of the history of ***SoonerCare Choice*** includes the following milestones:

Date	Milestone
April 1996	***SoonerCare Choice*** is piloted for TANF beneficiaries in three rural counties
October 1996	***Choice*** is expanded to all rural (non-***Plus***) counties for TANF beneficiaries. All contracts are with individual providers/clinics
December 1997	SCHIP beneficiaries added to ***Choice***
July 1999	State implements group contracting
January 2000	Phased-in enrollment begins for persons categorized as ABD (phase-in completed in April 2000)
January 2001	Second ***Plus*** geographic expansion reduces ***Choice*** to its current size of 61 counties
July 2001	PCCM contracts released for American Indian providers
April 2003	Elimination of retroactive eligibility period for TANF beneficiaries enrolled in managed care

ACHIEVEMENT OF PROGRAM OBJECTIVES

Access

As noted earlier, the ***SoonerCare*** waiver program was developed to address, in a fiscally responsible manner, the growing imbalance between need and availability of services. To a great extent, this imbalance has been eliminated by improving access to primary and preventive care services for demonstration members. Under all three models – full capitation (MCO), partial capitation PCCM and American Indian PCCM – ***SoonerCare*** has guaranteed enrollees a medical home where they receive primary/preventive care and referrals to medically necessary specialty services.

Whereas the traditional fee-for-service program had no access standards, under ***SoonerCare*** providers are required to meet a "days to appointment" standard for primary care. These standards are:

- 24 hours for urgent medical problems;
- 48-72 hours for sick visits; and
- Three weeks for routine preventive care.

SoonerCare members also may call a Nurse Advice/Triage line for consultation. These Nurse lines are available on a 24-hour basis.

Networks

The three ***SoonerCare Plus*** health plans have contracted to provide services for up to 350,000 members, or nearly double the actual current enrollment of 178,640. Plans must assure that members in the urban areas of Oklahoma City, Tulsa and Lawton have access to a primary care physician within a five-mile radius of their home. Members in other parts of the service areas must have access to a primary care physician within 25 miles or 45 minutes driving time. The plans are also contractually required to offer comprehensive networks with sufficient numbers of providers of the following types: physicians, OB/GYNs, specialists, hospitals, pharmacies, vision, behavioral health, certified nurse midwives, and essential community and special needs providers.

The Oklahoma Health Care Authority (OHCA) regularly evaluates the adequacy of each plan's network through a variety of methods, including the annual plan procurement process, routine operational audits and targeted audits in advance of major program changes. For example, prior to enrollment of persons categorized as ABD members and expansion of the program to new service areas, OHCA conducted extensive reviews of plan network adequacy, focusing particularly on specialties with high use rates among the disabled. Overall, OHCA has performed ten on-site reviews of the health plans during the past four years, averaging one every five months. This figure does not include quality improvement audits performed by the State's External Quality Review Organization, which are discussed further below.

Like many other states with Medicaid managed care programs, Oklahoma has seen a contraction in the number of participating health plans over the last several years. However, enrollees continue to be offered two health plans in each service area, and these plans continue to maintain comprehensive provider networks to serve their members.

In the ***Choice*** program, where the State contracts with 785 providers (combined American Indian and the partially-capitated PCCM providers), there are more than 700,000 openings for the program's 153,454 members, or over five times the necessary capacity. The program complies with a 45-minute or 45-mile distance access standard in all areas where the program operates, even the most rural counties. When ***Choice*** was initiated, only physicians and nurse practitioners could serve as contractors. To further boost capacity, Physician Assistants were added in year two and group contracting in

year four. To support this network infrastructure, the State has regionally-designated Provider representatives, a toll-free provider helpline, a systematic on-site provider training program, a specific ***Choice*** provider training manual, Exceptional Needs Coordinators to facilitate specialty care alignment and coordination of members with medically diverse/complex needs, and a non-emergency transportation system. To further improve the program and to gain provider input, on-site PCP/CM reviews and phone surveys are performed.

Funding Mechanisms

As previously described, the State relies on full capitation in the ***Plus*** service areas and a combination of partial capitation and fee-for-service in the ***Choice*** counties. Although MCO capitation rates were established through a competitive bidding process in the early years of the program, the rates today are developed by the State in consultation with its actuaries (partial capitation rates have always been set by the State). Oklahoma is in the process of developing calendar year 2004 actuarially-certified capitation rates in compliance with the BBA of 1997 for submission to CMS in the fall 2003.

The use of capitation as part of ***SoonerCare*** has enabled the State to bring a degree of budget predictability and cost control that did not exist prior to the waiver. Detailed information on waiver expenditures is included in the Budget Neutrality section of the application.

In addition to achieving greater budget predictability, the State also began ***SoonerCare*** with the intent of bringing about a more equitable distribution of health care dollars, on a per capita basis, between urban and rural Oklahoma. In 1995, prior to the waiver, beneficiaries in rural areas received approximately $0.86 of services for every $1.00 spent on their urban counterparts (for services covered under the waiver). By 2001, the two groups were nearly at parity.

Quality

The ***SoonerCare*** program has established new standards for accountability in health care delivery to Oklahoma's Medicaid population. The State's quality assurance monitoring provides State and federal agencies, health plans, providers and, most importantly, consumers and advocates with information about the quality of care delivered by health plans and PCP/CMs, in addition to information about member satisfaction.

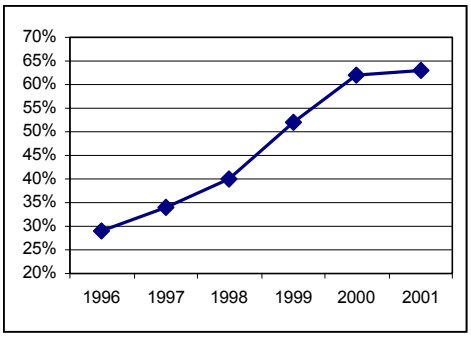
Oklahoma has been publishing quality indicators for Medicaid managed care since 1996. Quality reports are published annually for submission to CMS, and are also made available for public review. Some of the reports have been analyzed in a research format and submitted for publication in professional journals and presentation in professional meetings. Executive summaries and other synopses have been made available for a variety of audiences, including Medicaid consumers.

OHCA relies on several monitoring tools for data collection and analysis:

- EQRO monitoring through QISMC, including Performance Improvement Projects;
- Analysis of HEDIS data submitted annually by the contracted HMOs;
- Review of CAHPS surveys conducted by the EQRO; and
- Review of the GPRA Immunization project results, conducted in conjunction with the Oklahoma State Department of Health.

With these tools, the State collects information on managed care quality, access, utilization and member satisfaction for plans and PCP/CMs that serve Medicaid managed care enrollees. The consistent monitoring of Medicaid managed care data has allowed Oklahoma to target areas of underperformance and to track subsequent improvements in Medicaid performance measures. One of the most dramatic areas of improvement has been EPSDT screen rates, which have shown a consistent and significant upward trend, from a low of 29 percent in 1996 to 63 percent in 2001. The rate, by year, is shown below.

1996 - 29 percent
1997 - 34 percent
1998 - 40 percent
1999 - 52 percent
2000 - 62 percent
2001 – 63 percent



Oklahoma also has performed well in comparison to the nation as a whole, as demonstrated in the table below, which contains 2000 National Medicaid Benchmark and Oklahoma-specific figures.

Measure	**2000 National Medicaid Benchmark**	**2000 *SoonerCare Plus* Rate**	**2000 *SoonerCare Choice* (PCP/CM) Rate**
Adult Access to Preventive/Ambulatory Svcs 20–44 years of age	N/A	67 percent	67 percent
Cervical Cancer Screen Rate	59 percent	51 percent	N/A
Child Access to Primary Care Providers 12 – 24 months	82 percent	82 percent	88 percent
Child Access to Primary Care Providers 2 – 6 years	72 percent	68 percent	73 percent
Child Access to Primary Care Providers 7 – 11 years	72 percent	75 percent	85 percent
Dental Visits 4 – 21 years	N/A	30 percent	34 percent
ER Visits (per 1,000 member months)	420 visits	440 visits	530 visits

To achieve these results, OHCA has worked closely with its contracted health plans and PCP/CMs on a range of performance improvement activities. The State has also made concerted efforts to assure that quality data is made available both to Medicaid beneficiaries and the public at large.

Quality data is published in regional brochures entitled "A Consumer's Guide to Medicaid Managed Care". These guides are available in local district offices and are included in the enrollment packets sent out by the State's enrollment broker in Oklahoma City. In addition, in November 2001, "eQARR 2001- An Interactive Report on Managed Care Performance" was made public on the Oklahoma State Department of Health's website. "eQARR 2001" contains results from the 2000 QARR and the Consumer Assessment of Health Plans survey (CAHPS).

SoonerCare Plus plans also participate in Performance Improvement Projects under QISMC. Plans are required to conduct the State-designated EPSDT project in conjunction with the EQRO, as well as at least one study topic annually of their own choosing. The Performance Improvement Projects are monitored and evaluated by the EQRO with documented Annual Reports.

Plan-selected study topics include:

- Appeals and Grievances Process Evaluation
- Call Center Evaluation
- Improved Dental Services
- Depression
- Checkups After Delivery
- Diabetes
- Cervical Cancer Screen
- Asthma
- Childhood Immunizations

Finally, OHCA also works in collaboration with the Oklahoma State Department of Health (OSDH) in conducting an annual GPRA project on childhood immunizations. Oklahoma was a Group One State and has just completed the third year of the GPRA Project. The rates initially increased from a baseline of 65 percent to 76 percent in year two**.** Unfortunately, a shortage in VFC supplies for the third year of the project resulted in declines in immunization rates. Due to the project success in the first two years, OHCA will continue the collaboration with OSDH in an effort to further improve vaccine rates among Medicaid children.

The State is pleased with progress made to date as the result of ongoing quality improvement activities and looks forward to building on this progress during the second extension period.

Budget Neutrality

Oklahoma has consistently remained below budget neutrality limits throughout the life of the ***SoonerCare*** waiver. The tables at the back of this application contain budget neutrality information for the extension period and are derived from data previously submitted on HCFA-64 reports[1].

Table 1 presents actual program expenditures, by MEG, versus waiver budget neutrality limits in Demonstration Year 6 (Extension Year 1). Table 2 presents the same information for Demonstration Year 7. Table 3 presents the same information for the first six months of Demonstration Year 8.

Table 4 presents cumulative waiver savings over the first seven years of the ***SoonerCare*** demonstration. As it shows, total savings to-date stand at approximately $915 million (State and Federal). Oklahoma requests that these savings be carried over into the next extension period with the understanding that they may only be applied to a CMS-approved eligibility expansion or to offset demonstration costs in excess of the annual budget limits during this period.

Oklahoma requests an annual trend factor for the second extension period set equal to the projected rates developed by the Office of the Actuary for Federal Fiscal Years 2004 – 2006. Oklahoma's recent experience has actually exceeded Office of the Actuary projections and the State therefore considers this to be a reasonable request.

The specific trend rates requested for all MEGs are:

Demonstration Year Nine - 6.4 percent
Demonstration Year Ten - 7.4 percent
Demonstration Year Eleven - 7.7 percent

Compliance With Special Terms And Conditions

Oklahoma has consistently complied with waiver Special Terms and Conditions and the Operational Protocol, which details how ***SoonerCare*** is to be administered in accordance with the Terms and Conditions. OHCA completes quarterly reports, participates in monthly monitoring calls and obtains program guidance and consultation as needed from CMS.

As previously discussed, Oklahoma has performed frequent health plan readiness reviews and operational compliance audits throughout the history of ***SoonerCare***. OHCA staff assist program contractors with operational issues, problem resolution and improvement strategies on a year-round basis.

[1] The State is in the process of finalizing expenditure data for the first quarter of calendar year 2003 and will make it available to CMS in the near future.

OHCA is committed to working with CMS partners at the Regional and Central Office level to ensure that the program complies fully with the required Terms and Conditions.

STATE NOTICE PROCEDURE

Public Notice

Oklahoma has complied with the State Notice procedures for public notice, as published in the *Federal Register* in September 1994. The State announced its intention to request an extension of the ***SoonerCare*** waiver at the following public meetings this summer:

- ***SoonerCare Plus*** Health Plans Medical Directors' Meeting, presented by Rebecca Pasternik-Ikard, Director of ***SoonerCare*** and Care Management (May 19, 2003)

- ***Soonercare Plus*** Health Plan On-site Compliance Audits (Prime Advantage: May 23, 2003; Heartland Health Plan: June 16, 2003; and UniCare Health Plan: June 30, 2003)

- Medical Advisory Committee Meeting, Oklahoma City, presented by Rebecca Pasternik-Ikard, Director of ***SoonerCare*** and Care Management (July 8, 2003)

- Oklahoma Health Care Authority Board of Directors Meeting, Tahlequah, presented by Lynn Mitchell, MD, Director of Medicaid and Medical Services (July 10, 2003)

- ***SoonerCare Plus*** Behavioral Health Status Meeting, Oklahoma City, presented by Melinda Jones, Senior Compliance Analyst (August 25, 2003)

An announcement was also published in the following major daily newspapers:

- Tulsa World (August 5, 2003)
- The Daily Oklahoman (August 6, 2003)
- The Lawton Constitution (August 7, 2003)

The Oklahoma City and Tulsa papers have statewide circulations and thus are the most effective media for reaching all parts of Oklahoma.

Tribal Consultation

Oklahoma has complied with CMS tribal government notification requirements outlined in the State Medicaid Director letter of July 17, 2001. During an inter-tribal meeting held in Oklahoma City on May 7, 2003, the State's intention to file an 1115 waiver extension request was announced. The purpose of the waiver extension request and the impact on Tribal members were discussed. Subsequently, written notification was distributed to all

of the tribes providing for the requisite 30 day comment period. However, no comments or questions were received.

WAIVERS REQUESTED FOR THE EXTENSION PERIOD

Oklahoma requests re-authorization of all existing waivers for the extension period. The State also request that it be permitted to continue three elements of the existing program that are otherwise scheduled to expire on December 31 in accordance with requirements of the Balanced Budget Act of 1997. All three exceptions are being sought because they represent long-standing and successful elements of the program that would be both costly and disruptive to change.

First, the State requests the authority to continue to require adults enrolled in ***SoonerCare Plus*** to seek family planning services from network providers and adults enrolled in ***SoonerCare Choice*** to seek such services from their PCP/CMs.

Second, the State requests to be allowed to continue to impose a health plan lock-in of ***SoonerCare*** enrollees after their thirtieth day of enrollment, rather than ninety days as specified under BBA. Oklahoma will continue to permit enrollees after the thirtieth day to change plans if they show good cause.

Third, and finally, the State requests to be allowed to continue automatic re-enrollment of individuals who lose and regain eligibility within a 180-day period into their previous health plan (or with their previous PCP/CM), rather than limiting this rule to sixty days, as specified under BBA.

Table 1 – Demonstration Year 6

Eligibility Category	WY 01 Member Months	WY 01 Net Expenditures	Waiver Yr. Ext 1 Actual PMPM	FFY01 UPL PMPM	Growth Factor from Waiver Yr. 5 to Wvr.Yr. Ext 1	Wvr. Yr. Ext 1 PMPM Allowed	(Over/Under Budget Neutrality	%
AFDC-Urban	1,988,010	311,964,539.98	$156.92	$156.49	6.51%	$166.68	$9.76	5.85%
AFDC-Rural	1,915,864	249,934,052.06	$130.46	$158.73	6.51%	$169.06	$38.61	22.84%
ABD-urban (regardless of SSI eligibility)	279,689	101,645,621.24	$363.42	$567.56	5.86%	$600.82	$237.39	39.51%
ABD-rural (regardless of SSI eligibility)	329,747	109,707,132.66	$332.70	$452.30	5.86%	$478.80	$146.10	30.51%
Total Waiver Yr. 2000	4,513,310	$773,251,345.95						
Ext. Waiver Year #5	Member Months (Enrolled & Unenrolled)	Wvr. Yr. Ext 1 PMPM Allowed	Costs Without Waiver	Waiver Costs on HCFA-64			(Over)/Under Budget Neutrality	%
AFDC-Urban	1,988,010	$166.68	$331,363,063	311,964,540			$19,398,523	5.85%
AFDC-Rural	1,915,864	$169.06	$323,901,164	249,934,052			$73,967,112	22.84%
ABD-urban (regardless of SSI eligibility)	279,689	$600.82	$168,041,367	101,645,621			$66,395,746	39.51%
ABD-rural (regardless of SSI eligibility)	329,747	$478.80	$157,884,116	109,707,133			$48,176,983	30.51%
Total Waiver Yr. 6	4,513,310		$981,189,710	$773,251,346			$207,938,364	21.19%

Table 2 – Demonstration Year 7

Eligibility Category	WY 2002 Member Months	WY 2002 Net Expenditures	Waiver Yr. Ext 2 Actual PMPM	FFY02 UPL PMPM	Growth Factor from Wvr. Ext Yr. 1 to Wvr.Yr. Ext 2	Wvr. Yr. Ext 2 PMPM Allowed	(Over)/Under Budget Neutrality	%
AFDC-Urban	2,159,002	$337,784,795	$156.45	$166.68	6.51%	$177.53	$21.08	11.87%
AFDC-Rural	2,014,674	$270,655,613	$134.34	$169.06	6.51%	$180.07	$45.73	25.39%
ABD-urban (regardless of SSI eligibility)	306,526	$123,244,291	$402.07	$600.82	5.86%	$636.02	$233.95	36.78%
ABD-rural (regardless of SSI eligibility)	343,627	$120,361,978	$350.27	$478.80	5.86%	$506.86	$156.59	30.89%
Total Waiver Yr. 2002	4,823,829	$852,046,678						
Ext. Waiver Year #2	Member Months (Enrolled & Unenrolled)	Wvr. Yr. Ext 2 PMPM Allowed	Costs Without Waiver	Waiver Costs on HCFA-64			(Over)/Under Budget Neutrality	%
AFDC-Urban	2,159,002	$177.53	$383,287,625	$337,784,795			$45,502,830	11.87%
AFDC-Rural	2,014,674	$180.07	$362,782,347	$270,655,613			$92,126,734	25.39%
ABD-urban (regardless of SSI eligibility)	306,526	$636.02	$194,956,667	$123,244,291			$71,712,375	36.78%
ABD-rural (regardless of SSI eligibility)	343,627	$506.86	$174,170,781	$120,361,978			$53,808,803	30.89%
Total Waiver Yr. 7	4,823,829		$1,115,197,420	$852,046,678			$263,150,742	23.60%

Table 3 – Demonstration Year 8 (First Six Months)

Eligibility Category	CY 2003 Member Months	CY 2003 Net Expenditures	Waiver Yr. Ext 3 Actual PMPM	FFY03UPL PMPM	Growth Factor from Wvr. Ext Yr. 1 to Wvr.Yr. Ext 3	Wvr. Yr. Ext 3 PMPM Allowed	(Over/Under Budget Neutrality	%
AFDC-Urban	1,140,466	$164,596,220	$144.32	$177.53	6.51%	$189.09	$44.77	23.67%
AFDC-Rural	960,790	$126,420,324	$131.58	$180.07	6.51%	$191.79	$60.21	31.39%
ABD-urban (regardless of SSI eligibility)	114,754	$62,791,274	$547.18	$636.02	5.86%	$673.29	$126.11	18.73%
ABD-rural (regardless of SSI eligibility)	109,342	$52,678,404	$481.78	$506.86	5.86%	$536.56	$54.78	10.21%
Total Waiver Yr. 2003		$406,486,223						
Ext. Waiver Year #3	Member Months (Enrolled & Unenrolled)	Wvr. Yr. Ext 3 PMPM Allowed	Costs Without Waiver	Waiver Costs on HCFA-64			(Over)/Under Budget Neutrality	%
AFDC-Urban	1,140,466	$189.09	$215,650,716	$164,596,220			$51,054,496	23.67%
AFDC-Rural	960,790	$191.79	$184,269,914	$126,420,324			$57,849,590	31.39%
ABD-urban (regardless of SSI eligibility)	114,754	$673.29	$77,262,721	$62,791,274			$14,471,446	18.73%
ABD-rural (regardless of SSI eligibility)	109,342	$536.56	$58,668,544	$52,678,404			$5,990,139	10.21%
Total Waiver Yr. 8	2,325,352		$535,851,894	$406,486,223			$129,365,671	24.14%

Table 4 – Cumulative Waiver Savings

Waiver Year	Member Months (Enrolled & Unenrolled)	Costs Without Waiver	Waiver costs on HCFA-64	Variance
Total -Waiver Year #1	2,337,532	$286,138,649	$249,006,422	$37,132,227
Total -Waiver Year #2	2,282,744	$297,653,392	$281,953,273	$15,700,119
Total -Waiver Year #3	2,550,505	$354,302,018	$303,644,031	$50,657,987
Total -Waiver Year #4	3,198,323	$538,659,237	$426,247,022	$112,412,215
Total -Waiver Year #5	3,496,979	$690,766,574	$592,301,080	$98,465,494
Total -Ext. Waiver Year #1	4,513,310	$981,189,710	$773,251,346	$207,938,364
Total -Ext. Waiver Year #2	4,823,829	$1,115,197,420	$852,046,678	$263,150,742
Six Mos - Ext. Waiver Year #3	2,325,352	$535,851,894	$406,486,223	$129,365,671
Total Waiver Cost	25,528,574	$4,799,758,893	$3,884,936,074	$914,822,819